

FILED AUG 14 1945

Registration District No. 7

Primary Registration District No. 302J

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Howell
 (b) City or town West Plains, Mo
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
West Plains Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 hours
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
 (c) City or town Teresita, Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. Rural
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME No Name

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced, Child

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 7th 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 2 hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Clifford A. Lind
 13. Birthplace Illinois
(City, town, or county) (State or foreign country)
 14. Maiden name Aleene Orchard
 15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Clifford A. Lind
 (b) Address Teresita, Mo

17. (a) Burial (b) Date thereof July 9th, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pilgrims Rest Cem.

18. (a) Signature of funeral director Thomas A. Meaney
 (b) Address Mountain View, Mo

19. (a) 7-30-45 (b) Carl S. Larkin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th
 year 1945 hour 12 minute 35 a.m.

21. I hereby certify that I attended the deceased from 7/7/45
 _____, 1945 to 7/7/45, 1945;
 that I last saw her alive on 7/7/45, 1945;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
to 440 Respiratory
E. clausure of
arteries
 Due to _____
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
154

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) ✓
 (b) Date of occurrence _____
 (c) Where did injury occur? X _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
X

While at work? X (Specify type of place) _____
 Means of injury _____
 23. Signature Walter Haysman (M. D. or other) MD
 Address West Plains, Mo Date signed 7/27/45

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT

MOTHER FATHER

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 845-312

Date Filed 8.13.45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

John J. Mean

Licensed Embalmer No. 2516

P. O. Address Stu Veer Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.